Acceptable POC #2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445024	A. BUILDING _____ B. WING _____	03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, JOHNSON CITY	3209 BRISTOL HWY JOHNSON CITY, TN 37601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification and complaint survey #33256, were completed on March 19, 2014, at NHC Healthcare Johnson City. No deficiencies were cited in relation to the complaint under 42 CFR PART 482.13, Requirements for Long Term Care	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to assess for the use of a restraint prior to starting a potential restraint for two residents (#164,#152) of twenty-six residents reviewed. The findings included: Resident #164 was admitted to the facility on November 24, 2010, with diagnoses including Dementia, Anxiety, Hypertension, and Atrial Fibrillation. Observation on March 17, 2014, at 2:30 p.m., and March 18, 2014, at 3:12 p.m., revealed resident #164 on the 300 hall in a reclined wheelchair. Medical record review of a care plan dated February 5, 2014, revealed "...11/27/13 resident placed in gerichair...1/3/14 resident to be up in rocking wheelchair (type of reclined wheelchair)	F 221	F221 Residents #152 and #164 have been assessed for restraint potential by the Resident Care Coordinator and documented as non-restraints on the restraint assessment. All residents will be evaluated by the respective Resident Care Coordinator for the potential of reclining chairs being used as restraints, and documented on the restraint assessment. All reclining-style chairs, whether restraints or not, will be assessed as potential restraints before they are put in use; or as soon as possible after emergency implementation to treat a medical symptom. Staff meetings will be held with licensed nurses to review reclining-chair restraint potential. The Resident Care Coordinator will be responsible for reviewing each resident for reclining chair usage at least quarterly on a routine basis. A review of each resident and their current reclining chair status, including the corrective actions from this plan of correction, will be presented at the facility's monthly QA meeting in April. The ADON will review any newly implemented reclining chairs, if applicable, during the month of April and report to next QA committee in April.	4/25/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 4/3/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 during the day as tolerated..." Medical record review of a physical restraint review dated January 28, 2014 revealed, "...pt (patient) is up to gerichair daily..." Interview on March 18, 2014, at 1:44 p.m., with Resident Care Coordinator (RCC) #1 at the 300 hall nurse's desk, revealed the resident was placed in the gerichair on November 27, 2013, and a restraint assessment was not completed till January 28, 2014, "two months later." Continued interview revealed the recline wheelchair was not assessed prior to placing the resident in the wheelchair on January 3, 2014. Interview on March 19, 2014, at 9:23 a.m., in the RCC office confirmed the facility failed to assess the gerichair and rocking wheelchair prior to starting for a potential restraint. Resident #152 was admitted to the facility on February 12, 2014, with diagnoses including, Urinary Tract Infection, Delirium, Anorexia, Chronic Anxiety, Depression, Hypertension, Dementia, Psychosis, Delusions, and Insomnia. Observation of the resident in the resident's room on March 17, 2014, at 1:42 p.m., revealed the resident sitting in a Broda chair (type of reclining chair). Review of the Interim Care Plan dated February 12, 2014, revealed "...2/21/14, Broda chair d/t (due to) fall..." Continued review of the medical record revealed the facility failed to complete a Pre-Restraint Assessment for the Broda chair until March 4,	F 221		

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F 221	Continued From page 2 2014, a delay of eleven days. Interview with the Station one Resident Care Coordinator (RCC) on March 18, 2014, at 11:45 a.m., at the Station one Nurse's Station confirmed the facility failed to perform a Pre-Restraint Assessment prior to initiating use of the Broda chair.	F 221		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to evaluate the bladder incontinence status of one resident (#162) of twenty-six residents reviewed. The findings included: Resident # 162 was admitted to the facility on November 8, 2013, with diagnoses including Coronary Artery Disease, Urinary Incontinence, Chronic Edema, Osteoarthritis, Hyperlipidemia, Contracture of Hands, Osteoarthritis, Hypertension.	F 315	F315 Resident #162 will have a complete incontinence assessment completed by Resident Care Coordinator. The MDS Coordinator and Resident Care Coordinator will review all residents who are incontinent and ensure they have complete incontinence assessments. All residents will be assessed for incontinence in conjunction with each resident's admission, quarterly, and annual review by the MDS Coordinator. The MDS Coordinator will notify the Resident Care Coordinator of incontinence assessment results for further care plan development. Procedure will be reviewed with nursing administration at next staff meeting. The ADON will review a sample of residents on each station for a complete incontinence assessment; weekly times two weeks, and report to next QA committee in April. There will be routine annual reviews by the MDS Coordinator and Resident Care Coordinator.	4/25/2014

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F 315	Continued From page 3 Medical record review of the current care plan for the resident indicated that the resident was at risk for alteration in skin integrity due to urinary incontinence, with an intervention of assisting the resident with toileting as needed. Medical record review revealed two forms entitled Incontinence Screening, one dated November 8, 2013, and the other dated November 16, 2013. Both forms were complete on page one, Both forms indicated Resident # 162 "scored a five on the incontinence screening and is a candidate for a bowel/bladder program at this time and is willing and/or able to participate in a continence program". Further review of the Incontinence Screening form dated November 8, 2013, revealed Resident # 162 "actively wants to regain bladder control". Continued review of both Incontinence Screening forms revealed the second page to be blank and the section of the forms "Complete the following algorithm to determine the appropriate incontinence management program" was not completed. Further review revealed the section " After completing the management algorithm, the program best suited to meet the patient's needs was:" had not been completed and a bladder training program had not been identified on the form for the resident. Interview with Licensed Practical Nurse (LPN) #1 on March 18, 2014, at 1:57 p.m., at Nurse Station Two, revealed Resident #162 was incontinent of urine mostly at night and occasionally during the day. Continued interview revealed the resident was not on a scheduled toileting program. Further interview revealed "We offer to take... to the bathroom at least every two hours. The facility	F 315		

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F 315	Continued From page 4 standard for residents who need assistance with toileting is to offer every two hours." Interview with MDS (minimum data set) Coordinator #1 on March 19, 2014, at 10:12 a.m., revealed the incontinence screening form, both page one and two, were to have been completed by the MDS coordinator. An incontinence training program for the resident was to have been identified on the form. The information on the form was then to be relayed to the Resident Care Coordinator at the resident's station. Further interview with the MDS Coordinator #1 confirmed page two of the incontinence screening forms dated November 8, and November 18, 2013, for Resident #162 had not been completed and no incontinence program had been identified.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322	F322 Resident #169 will have tube feeding properly labeled (completed while surveyors still in building). The Resident Care Coordinator will review all residents who receive tube feeding and ensure the tube feeding has been properly labeled. No problems noted. Tube feeding labeling procedure will be reviewed with nurses at next staff meeting by DON. The ADON will review all residents on each station for properly labeled tube feeding; weekly times two weeks, and report to next QA committee in April.	4/25/14 3/31/14 4/25/2014

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F 322	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure tube feedings were properly labeled for one resident (#169) of twenty-six residents reviewed. The findings included: Resident #169 was admitted to the facility on March 11, 2011, with diagnoses including Bilateral Above the Knee Amputation, Coronary Artery Disease, Cerebral Vascular Accident, Right Side Hemiparesis, Expressive Aphasia, Dysphagia, Gastrostomy, Failure to Thrive, Renal Failure, and Diabetes. Observation on March 17, 2014, at 2:52 p.m., in the resident's room, revealed the resident lying in the bed with Jevity 1.5 calorie (tube feeding) infusing at 65 milliliter (ml) per hour per the Percutaneous Endoscopic Gastrostomy (PEG) feeding tube. Continued observation revealed the tube feeding was not labeled with a start date or time. Interview with the Director of Nursing (DON) on March 17, 2014, at 3:22 p.m., in the resident's room, confirmed the facility failed to label the tube feeding with a date or time.	F 322		